House of Representatives

General Assembly

File No. 417

January Session, 2015

Substitute House Bill No. 6847

House of Representatives, April 2, 2015

The Committee on Insurance and Real Estate reported through REP. MEGNA of the 97th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT ENHANCING ACCESS TO BEHAVIORAL HEALTH SERVICES AND SERVICES FOR YOUTHS WITH AUTISM SPECTRUM DISORDER.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-514b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

(a) As used in this section:

(1) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior.

(2) **[**"Autism services provider"**]** <u>"Autism spectrum disorder services provider"</u> means any person, entity or group that provides treatment for autism spectrum disorder pursuant to this section.

(3) "Autism spectrum disorder" means **[**a pervasive developmental disorder**]** "autism spectrum disorder" as set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". **[**, including, but not limited to, Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.**]**

(4) "Behavioral therapy" means any interactive behavioral therapies derived from evidence-based research and consistent with the services and interventions designated by the Commissioner of Developmental Services pursuant to subsection (l) of section 17a-215c, as amended by this act, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with **[**an**]** autism spectrum disorder, that are: (A) Provided to children less than **[**fifteen**]** twenty-one years of age; and (B) provided or supervised by (i) a behavior analyst who is certified by the Behavior Analyst Certification Board, (ii) a licensed physician, or (iii) a licensed psychologist. For the purposes of this subdivision, behavioral therapy is "supervised by" such behavior analyst, licensed physician or licensed psychologist when such supervision entails at least one hour of face-to-face supervision of the autism spectrum disorder services provider by such behavior analyst, licensed physician or licensed psychologist for each ten hours of behavioral therapy provided by the supervised provider.

(5) "Diagnosis" means the medically necessary assessment, evaluation or testing performed by a licensed physician, licensed psychologist or licensed clinical social worker to determine if an individual has **[**an**]** autism spectrum disorder.

(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 that is delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for the diagnosis and

treatment of autism spectrum disorder. [, except that coverage for an insured under such policy who has been diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" shall be provided in accordance with subsection (i) of this section.] For the purposes of this section and section 38a-513c, [an] autism spectrum disorder shall be considered an illness.

(c) Such policy shall provide coverage for the following treatments, provided such treatments are (1) medically necessary, and (2) identified and ordered by a licensed physician, licensed psychologist or licensed clinical social worker for an insured who is diagnosed with [an] autism spectrum disorder, in accordance with a treatment plan developed by a licensed physician, licensed psychologist or licensed clinical social worker pursuant to a comprehensive evaluation or reevaluation of the insured:

(A) Behavioral therapy;

(B) Prescription drugs, to the extent prescription drugs are a covered benefit for other diseases and conditions under such policy, prescribed by a licensed physician, licensed physician assistant or advanced practice registered nurse for the treatment of symptoms and comorbidities of autism spectrum disorder;

(C) Direct psychiatric or consultative services provided by a licensed psychiatrist;

(D) Direct psychological or consultative services provided by a licensed psychologist;

(E) Physical therapy provided by a licensed physical therapist;

(F) Speech and language pathology services provided by a licensed speech and language pathologist; and

(G) Occupational therapy provided by a licensed occupational therapist.

[(d) Such policy may limit the coverage for behavioral therapy to a yearly benefit of fifty thousand dollars for a child who is less than nine years of age, thirty-five thousand dollars for a child who is at least nine years of age and less than thirteen years of age and twenty-five thousand dollars for a child who is at least thirteen years of age and less than fifteen years of age.**]**

[(e)**]** (d) Such policy shall not impose (1) any limits on the number of visits an insured may make to an autism spectrum disorder services provider pursuant to a treatment plan on any basis other than a lack of medical necessity, or (2) a coinsurance, copayment, deductible or other out-of-pocket expense for such coverage that places a greater financial burden on an insured for access to the diagnosis and treatment of **[**an**]** autism spectrum disorder than for the diagnosis and treatment of any other medical, surgical or physical health condition under such policy.

[(f)**]** (e) (1) Except for treatments and services received by an insured in an inpatient setting, an insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society may review a treatment plan developed as set forth in subsection (c) of this section for such insured, in accordance with its utilization review requirements, not more than once every six months unless such insured's licensed physician, licensed psychologist or licensed clinical social worker agrees that a more frequent review is necessary or changes such insured's treatment plan.

(2) For the purposes of this section, the results of a diagnosis shall be valid for a period of not less than twelve months, unless such insured's licensed physician, licensed psychologist or licensed clinical social worker determines a shorter period is appropriate or changes the results of such insured's diagnosis.

[(g)**]** (f) Coverage required under this section may be subject to the other general exclusions and limitations of the group health insurance policy, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and case management provisions,

except that any utilization review shall be performed in accordance with subsection **[**(f)**]** (e) of this section.

[(h)**]** (g) (1) Nothing in this section shall be construed to limit or affect (A) any other covered benefits available to an insured under (i) such group health insurance policy, (ii) section 38a-514, as amended by this act, or (iii) section 38a-516a, as amended by this act, (B) any obligation to provide services to an individual under an individualized education program pursuant to section 10-76d, or (C) any obligation imposed on a public school by the Individual With Disabilities Education Act, 20 USC 1400 et seq., as amended from time to time.

(2) Nothing in this section shall be construed to require such group health insurance policy to provide reimbursement for special education and related services provided to an insured pursuant to section 10-76d, unless otherwise required by state or federal law.

[(i) Each such group health insurance policy shall maintain, for any insured diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", coverage as set forth in this section for the treatment of said disorder at the benefit levels, at a minimum, provided immediately preceding the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".**]**

Sec. 2. Section 38a-488b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

(a) As used in this section:

(1) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior.

(2) "Autism spectrum disorder services provider" means any person, entity or group that provides treatment for an autism spectrum disorder pursuant to this section.

(3) "Autism spectrum disorder" means "autism spectrum disorder" as set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

(4) "Behavioral therapy" means any interactive behavioral therapies derived from evidence-based research and consistent with the services and interventions designated by the Commissioner of Developmental Services pursuant to subsection (l) of section 17a-215c, as amended by this act, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with autism spectrum disorder, that are: (A) Provided to children less than twenty-one years of age; and (B) provided or supervised by (i) a behavior analyst who is certified by the Behavior Analyst Certification Board, (ii) a licensed physician, or (iii) a licensed psychologist. For the purposes of this subdivision, behavioral therapy is "supervised by" such behavior analyst, licensed physician or licensed psychologist when such supervision entails at least one hour of face-to-face supervision of the autism spectrum disorder services provider by such behavior analyst, licensed physician or licensed psychologist for each ten hours of behavioral therapy provided by the supervised provider.

(5) "Diagnosis" means the medically necessary assessment, evaluation or testing performed by a licensed physician, licensed psychologist or licensed clinical social worker to determine if an individual has autism spectrum disorder.

[(a)**]** (b) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 that is delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage **[**for physical therapy, speech therapy and occupational therapy services**]** for the diagnosis and treatment of autism spectrum disorder. **[**, as set forth in the most

recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", to the extent such services are a covered benefit for other diseases and conditions under such policy, except that coverage for an insured under such policy who has been diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" shall be provided in accordance with subsection (b) of this section.**]** For the purposes of this section and section 38a-482a, autism spectrum disorder shall be considered an illness.

(c) Such policy shall provide coverage for the following treatments, provided such treatments are (1) medically necessary, and (2) identified and ordered by a licensed physician, licensed psychologist or licensed clinical social worker for an insured who is diagnosed with autism spectrum disorder, in accordance with a treatment plan developed by a licensed physician, licensed psychologist or licensed clinical social worker pursuant to a comprehensive evaluation or reevaluation of the insured:

(A) Behavioral therapy;

(B) Prescription drugs, to the extent prescription drugs are a covered benefit for other diseases and conditions under such policy, prescribed by a licensed physician, licensed physician assistant or advanced practice registered nurse for the treatment of symptoms and comorbidities of autism spectrum disorder;

(C) Direct psychiatric or consultative services provided by a licensed psychiatrist;

(D) Direct psychological or consultative services provided by a licensed psychologist;

(E) Physical therapy provided by a licensed physical therapist;

(F) Speech and language pathology services provided by a licensed speech and language pathologist; and

(G) Occupational therapy provided by a licensed occupational therapist.

(d) Such policy shall not impose (1) any limits on the number of visits an insured may make to an autism spectrum disorder services provider pursuant to a treatment plan on any basis other than a lack of medical necessity, or (2) a coinsurance, copayment, deductible or other out-of-pocket expense for such coverage that places a greater financial burden on an insured for access to the diagnosis and treatment of autism spectrum disorder than for the diagnosis and treatment of any other medical, surgical or physical health condition under such policy.

(e) (1) Except for treatments and services received by an insured in an inpatient setting, an insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society may review a treatment plan developed as set forth in subsection (c) of this section for such insured, in accordance with its utilization review requirements, not more than once every six months unless such insured's licensed physician, licensed psychologist or licensed clinical social worker agrees that a more frequent review is necessary or changes such insured's treatment plan.

(2) For the purposes of this section, the results of a diagnosis shall be valid for a period of not less than twelve months, unless such insured's licensed physician, licensed psychologist or licensed clinical social worker determines a shorter period is appropriate or changes the results of such insured's diagnosis.

(f) Coverage required under this section may be subject to the other general exclusions and limitations of the individual health insurance policy, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and case management provisions, except that any utilization review shall be performed in accordance with subsection (e) of this section.

(g) (1) Nothing in this section shall be construed to limit or affect (A)

any other covered benefits available to an insured under (i) such individual health insurance policy, (ii) section 38a-488a, as amended by this act, or (iii) section 38a-490a, as amended by this act, (B) any obligation to provide services to an individual under an individualized education program pursuant to section 10-76d, or (C) any obligation imposed on a public school by the Individual With Disabilities Education Act, 20 USC 1400 et seq., as amended from time to time.

(2) Nothing in this section shall be construed to require such individual health insurance policy to provide reimbursement for special education and related services provided to an insured pursuant to section 10-76d, unless otherwise required by state or federal law.

[(b) Each such policy shall maintain, for any insured diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", coverage for physical therapy, speech therapy and occupational therapy services for the treatment of said disorder at the benefit levels, at a minimum, provided immediately preceding the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".**]**

Sec. 3. Section 38a-516a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for medically necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e. Such policy shall **[**(1)**]** provide coverage for such services provided by qualified personnel, as defined in section 17a-248, for a child from birth until the child's third birthday. **[**, and (2) maintain, for any insured diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", coverage for such services for the treatment of

said disorder at the benefit levels, at a minimum, provided immediately preceding the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".**]**

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services, except that a high deductible health plan, as that term is used in subsection (f) of section 38a-520, shall not be subject to the deductible limits set forth in this section.

[(c) Such policy shall provide a maximum benefit of six thousand four hundred dollars per child per year and an aggregate benefit of nineteen thousand two hundred dollars per child over the total three-year period, except that for a child with autism spectrum disorder, as defined in section 38a-514b, who is receiving early intervention services as defined in section 17a-248, the maximum benefit available through early intervention providers shall be fifty thousand dollars per child per year and an aggregate benefit of one hundred fifty thousand dollars per child over the total three-year period as provided for in section 38a-514b. Nothing in this section shall be construed to increase the amount of coverage required for autism spectrum disorder for any child beyond the amounts set forth in section 38a-514b. Any coverage provided for autism spectrum disorder through an individualized family service plan pursuant to section 17a-248e shall be credited toward the coverage amounts required under section 38a-514b.**]**

[(d)**]** (c) No payment made under this section shall (1) **[**be applied by the insurer, health care center or plan administrator against or result in a loss of benefits due to any maximum lifetime or annual limits specified in the policy, (2)**]** adversely affect the availability of health insurance to the child, the child's parent or the child's family members insured under any such policy, or **[**(3)**]** (2) be a reason for the insurer, health care center or plan administrator to rescind or cancel such policy. Payments made under this section shall not be treated differently than other claim experience for purposes of premium

rating.

Sec. 4. Section 38a-490a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for medically necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e. Such policy shall **[**(1)**]** provide coverage for such services provided by qualified personnel, as defined in section 17a-248, for a child from birth until the child's third birthday. **[**, and (2) maintain, for any insured diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", coverage for such services for the treatment of said disorder at the benefit levels, at a minimum, provided immediately preceding the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".**]**

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services, except that a high deductible health plan, as that term is used in subsection (f) of section 38a-493, shall not be subject to the deductible limits set forth in this section.

[(c) Such policy shall provide a maximum benefit of six thousand four hundred dollars per child per year and an aggregate benefit of nineteen thousand two hundred dollars per child over the total three-year period.**]**

[(d)**]** (c) No payment made under this section shall (1) **[**be applied by the insurer, health care center or plan administrator against or result in a loss of benefits due to any maximum lifetime or annual limits specified in the policy, (2)**]** adversely affect the availability of

health insurance to the child, the child's parent or the child's family members insured under any such policy, or **[**(3)**]** (2) be a reason for the insurer, health care center or plan administrator to rescind or cancel such policy. Payments made under this section shall not be treated differently than other claim experience for purposes of premium rating.

Sec. 5. Section 17a-215c of the general statutes is amended by adding subsection (l) as follows (*Effective from passage*):

(NEW) (l) The Commissioner of Developmental Services, in consultation with the Autism Spectrum Disorder Advisory Council, shall designate services and interventions that demonstrate empirical effectiveness for the treatment of autism spectrum disorder. The commissioner shall update such designations periodically and whenever the commissioner deems it necessary to conform to changes generally recognized by the relevant medical community in evidence-based practices or research.

Sec. 6. Subdivision (3) of subsection (a) of section 38a-591c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(3) (A) Notwithstanding subdivision (2) of this subsection, for any utilization review for the treatment of a substance use disorder, as described in section 17a-458, the clinical review criteria used shall be: (i) The most recent edition of the American Society of Addiction **[**Medicine's Patient Placement Criteria**]** Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions; or (ii) clinical review criteria that the health carrier demonstrates is consistent with the most recent edition of the American Society of Addiction **[**Medicine's Patient Placement Criteria**]** Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, in accordance with subparagraph (B) of this subdivision.

(B) A health carrier that uses clinical review criteria as set forth in subparagraph (A)(ii) of this subdivision shall create and maintain a

document in an easily accessible location on such health carrier's Internet web site that (i) compares each aspect of such clinical review criteria with the American Society of Addiction **[**Medicine's Patient Placement Criteria**]** Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, and (ii) provides citations to peer-reviewed medical literature generally recognized by the relevant medical community or to professional society guidelines that justify each deviation from the American Society of Addiction **[**Medicine's Patient Placement Criteria**]** Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.

Sec. 7. (*Effective from passage*) (a) Not later than October 1, 2015, the Insurance Commissioner shall convene a working group to develop recommendations for behavioral health utilization and quality measures data that should be collected uniformly from state agencies that pay health care claims, group hospitalization and medical and surgical insurance plans established pursuant to section 5-259 of the general statutes, the state medical assistance program and health insurance companies and health care centers that write health insurance policies and health care contracts in this state. The purposes of such recommendations include, but are not limited to, protecting behavioral health parity for youths and other populations.

(b) The working group shall consist of the Insurance Commissioner, the Healthcare Advocate, the Commissioners of Social Services, Public Health, Mental Health and Addiction Services, Children and Families and Developmental Services and the Comptroller, or their designees, and may include representatives from health insurance companies or health care centers or any other members the Insurance Commissioner deems necessary and relevant to carry out the working group's duties under this section.

(c) (1) The working group shall determine the data that should be collected to inform analysis on (A) coverage for behavioral health services, (B) the adequacy of coverage for behavioral health conditions, including, but not limited to, autism spectrum disorders and substance

use disorders, (C) the alignment of medical necessity criteria and utilization management procedures across such agencies, plans, program, companies and centers, (D) the adequacy of health care provider networks, (E) the overall availability of behavioral health care providers in this state, (F) the percentage of behavioral health care providers in this state that are participating providers under a group hospitalization and medical and surgical insurance plan established pursuant to section 5-259 of the general statutes, the state medical assistance program, or a health insurance policy or health care contract delivered, issued for delivery, renewed, amended or continued in this state, and (G) the adequacy of services available for behavioral health conditions, including, but not limited to, autism spectrum disorders and substance use disorders.

(2) The recommendations developed by the working group may include data such as (A) per member, per month claim expenses, (B) the median length of a covered treatment for an entire course of treatment by levels of care, (C) utilization review outcome data grouped by levels of care, age categories and levels of review as set forth in part VII of chapter 700c of the general statutes, (D) the number of in-network and out-of-network health care providers by location and provider type, (E) health care provider network management data by location and provider type, and (F) health care provider network fluctuations, the causes of such fluctuations and the decisions made by health insurance companies, health care centers and state agencies regarding the approval of health care providers to join a health care provider network.

(d) Not later than January 1, 2016, the Insurance Commissioner shall submit a report of the recommendations of the working group as set forth in subsection (a) of this section, in accordance with the provisions of section 11-4a of the general statutes, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to insurance, human services, public health and children.

Sec. 8. Subsection (a) of section 38a-514 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

(a) Except as provided in subsection (j) of this section, each group health insurance policy, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for the diagnosis and treatment of mental or nervous conditions. For the purposes of this section, "mental or nervous conditions" means mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". "Mental or nervous conditions" does not include (1) intellectual disabilities, (2) specific learning disorders, (3) motor disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) other conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders"**.** **[**, except that coverage for an insured under such policy who has been diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" shall be provided in accordance with subsection (i) of section 38a-514b.**]**

Sec. 9. Subsection (a) of section 38a-488a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for the diagnosis and treatment of mental or nervous conditions. For the purposes of this section, "mental or nervous conditions" means mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic

and Statistical Manual of Mental Disorders". "Mental or nervous conditions" does not include (1) intellectual disabilities, (2) specific learning disorders, (3) motor disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) other conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". **[**, except that coverage for an insured under such policy who has been diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" shall be provided in accordance with subsection (b) of section 38a-488b.**]**

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2016*	38a-514b
Sec. 2	*January 1, 2016*	38a-488b
Sec. 3	*January 1, 2016*	38a-516a
Sec. 4	*January 1, 2016*	38a-490a
Sec. 5	*from passage*	17a-215c
Sec. 6	*July 1, 2015*	38a-591c(a)(3)
Sec. 7	*from passage*	New section
Sec. 8	*January 1, 2016*	38a-514(a)
Sec. 9	*January 1, 2016*	38a-488a(a)

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 16 $	FY 17 $
State Comptroller - Fringe Benefits (State Employee and Retiree Health Accounts)	GF, TF - Cost	Approximately $187,000	Approximately $374,000
The State	Cost	Approximately $118,021	Approximately $236,042

Note: GF=General Fund and TF = Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 16 $	FY 17 $
Various Municipalities	STATE MANDATE - Cost	At least $145,483	At least $290,967

Explanation

Explanation

Section 1 of the bill will result in a cost to the state employee and retiree health plan[1], municipalities, and the state, for providing coverage for autism services up to age 21. The total estimated cost to the state in FY 16 is approximately $305,201 and $610,042 in FY 17.[2] This cost is attributable to (1) the estimated cost to the state plan in FY 16 and FY 17 of approximately $187,000 and $374,000 respectively and (2) the cost to the state pursuant to the federal Affordable Care Act (ACA) (see below) in FY 16 and FY 17 of approximately $118,021 and

[1] The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state has traditionally adopted all state health mandates.

[2] The cost is based on FY 14 state plan expenditures for individuals up to age 15 receiving autism services in accordance with current law, and equates to approximately a per member per month (PMPM) cost of $0.19.

$236,042 respectively.[3] The cost to fully insured municipalities in FY 16 and FY 17 is approximately $145,483 and $290,967 respectively. There is not an impact to the state or municipalities from removing the annual coverage limits because no limits are currently imposed in practice in accordance with the ACA.

Municipal Impact

As previously stated, the bill will increase costs to certain fully insured municipal plans to provide coverage for autism services up to age 21. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2016. In addition, many municipal health plans are recognized as "grandfathered" health plans under the ACA.[4] It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA. Pursuant to federal law, self-insured health plans are exempt from state health mandates.

The State and the federal ACA

Lastly, the ACA requires that, the state's health exchange's qualified health plans (QHPs)[5], include a federally defined essential health benefits package (EHB). The federal government is allowing states to choose a benchmark plan[6] to serve as the EHB until 2016 when the federal government is anticipated to revisit the EHB.

While states are allowed to mandate benefits in excess of the EHB, the federal law requires the state to defray the cost of any such

[3] The cost to the state pursuant to the ACA may be underrepresented as it is uncertain if the enrollment information reported reflects the total number of covered lives by exchange plans or the number of individuals who purchased a policy.
[4] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.
[5] The state's health exchange, Access Health CT, opened its marketplace for Connecticut residents to purchase QHPs from carriers, with coverage starting January 1, 2014.
[6] The state's benchmark plan is the Connecticare HMO plan with supplemental coverage for pediatric dental and vision care as required by the ACA.

additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage. State mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB for 2014-2015 unless they are already part of the benchmark plan[7]. However, neither the agency nor the mechanism for the state to pay these costs has been established.

Sections 2 through 4, 6 through 9 of the bill do not result in a cost to the state and are not anticipated to result in a cost to municipalities. These sections (1) conform coverage for autism services in individual health insurance policies to that of group policies, (2) eliminate annual benefit caps for autism services already implemented in accordance with the ACA, (3) eliminate reference to the Diagnostic and Statistical Manual V in order to facilitate the bills coverage of autism services up to age 21, and (4) makes other technical and conforming changes.

Section 4 also eliminates the annual limits for Birth to Three services of $6,400 per child and $19,200 per child over the three year period which does not result in a fiscal impact as this conforms to current practice.

Section 5 requires the Department of Developmental Services Commissioner, in consultation with the Autism Spectrum Advisory Council, to designate demonstrated effective autism spectrum services and interventions. This provision has no fiscal impact as the agency has expertise in this area.

Section 7 does not result in a cost to the Department of Insurance to convene a working group, including other state agencies, to develop recommendations for behavioral health utilization and data collection.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to (1) inflation, (2) utilization of

[7] *Source*: Dept. of Health and Human Services. *Frequently Asked Questions on Essential Health Benefits Bulletin* (February 21, 2012).

services, and (3) the number of individuals in exchange plans.

Sources: *Department of Labor*
Office of the State Comptroller
Office of the State Comptroller State Health Plan, Health Benefit Document as of July 2015

OLR Bill Analysis

sHB 6847

AN ACT ENHANCING ACCESS TO BEHAVIORAL HEALTH SERVICES AND SERVICES FOR YOUTHS WITH AUTISM SPECTRUM DISORDER.

SUMMARY:

This bill:

1. expands certain individual and group health insurance policies' required coverage of autism spectrum disorder (ASD) services and treatment;

2. requires the developmental services (DSS) commissioner to designate demonstrated effective ASD services and interventions;

3. expands existing law's group policy behavioral therapy coverage for individuals with ASD and also applies it to individual policies;

4. eliminates maximum coverage limits on the Birth-To-Three program;

5. requires the insurance commissioner to convene a working group to develop recommendations on behavioral health data collection; and

6. makes technical and conforming changes.

The coverage provisions apply to health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses, (2) basic medical-surgical expenses, (3) major medical expenses, or (4) hospital or medical services, including those provided through an HMO.

EFFECTIVE DATE: January 1, 2016, except for the DSS designated effective treatment and the data collection working group provisions, which are effective upon passage, and certain technical changes, which are effective July 1, 2015.

COVERAGE AND LIMITATIONS FOR ASD SERVICES IN HEALTH INSURANCE POLICIES

The bill requires individual policies to conform to several coverage and limitation provisions that existing law requires of group policies in regard to ASD-related services.

Covered ASD Services in Individual Policies

Current law requires individual health insurance policies to cover physical therapy, speech therapy, and occupational therapy services for individuals with ASD to the extent that such services are covered for other diseases and conditions under the policy. Under the bill, individual policies must cover ASD diagnosis and treatment including:

1. behavioral therapy;

2. prescription drugs prescribed by a licensed physician, physician assistant, or advanced practice registered nurse to treat ASD symptoms and comorbidities, to the extent they are covered for other conditions under the policy;

3. direct (a) psychiatric or consultative services provided by a licensed psychiatrist and (b) psychological or consultative services provided by a licensed psychologist; and

4. physical therapy, speech and language pathology services, and occupational therapy provided by a licensed physical therapist, speech and language pathologist, or occupational therapist, respectively.

ASD Treatment Requirements in Individual Policies

Individual policies must cover treatments for individuals with ASD that are:

1. medically necessary,

2. identified and ordered by a licensed physician, psychologist, or clinical social worker; and

3. in accordance with a treatment plan developed by a licensed physician, psychologist, or clinical social worker pursuant to a comprehensive evaluation or reevaluation.

The bill also specifies ASD constitutes an illness for the purposes of medical necessity.

Limitations and Prohibitions on Coverage

The bill prohibits individual policies from:

1. limiting the number of visits an insured may make to an ASD provider pursuant to a treatment plan on any basis other than lack of medical necessity, and

2. requiring coinsurance, copayments, deductibles, or other out-of-pocket expenses that place a greater financial burden on access to ASD diagnosis and treatment than the diagnosis and treatment of any other covered medical, surgical, or physical health condition.

The bill prohibits insurers, HMOs, medical service corporations and fraternal benefit societies from reviewing a treatment plan, in accordance with its utilization review requirements, more than once every six months unless the insured's licensed physician, psychologist or clinical social worker (1) agrees a more frequent review is necessary or (2) changes the insured's treatment plan. The bill exempts inpatient treatments and services from this provision.

The bill requires diagnoses be valid for at least one year, unless the insured's licensed physician, psychologist, or clinical social worker (1) determines a shorter period is appropriate or (2) changes an insured's diagnosis.

The bill specifies that coverage is subject to other general exclusions and limitations of individual health insurance policies, including coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, and case management provisions.

The bill also specifies coverage must not be construed to:

1. limit or affect any other covered benefits available (a) under the policy, (b) specific to mental and nervous conditions, or (c) through the Birth-To-Three program;

2. limit or affect any obligation to (a) provide services under an individualized education plan, or (b) imposed on a public school by the federal Individuals With Disabilities Education Act; and

3. provide reimbursement for special education and related services, unless required by state or federal law.

BEHAVIORAL THERAPY COVERAGE FOR INDIVIDUALS WITH ASD UNDER INDIVIDUAL AND GROUP HEALTH INSURANCE POLICIES

Existing law defines behavioral therapy under group policies as any interactive behavioral therapy derived from evidence-based research, including applied behavior analysis (see below) and cognitive behavioral therapy. Behavioral therapy also includes other therapies, supported by empirical evidence of their effectiveness in treating individuals with ASD, that are:

1. provided to children under 15, and

2. either provided or supervised by a (a) behavior analyst certified by the Behavior Analyst Certification Board, (b) a licensed physician, or (c) a licensed psychologist. ("Supervised by" is the face-to-face supervision of ASD services for at least one hour for each 10 hours of therapy the supervised individual provides).

By law, such coverage is subject to a maximum yearly benefit based on the child's age.

The bill makes the following changes to group policies and also applies them to individual policies:

1. repeals the yearly coverage limit,
2. requires therapy be provided to children up to age 21,
3. requires therapy be consistent with the services and interventions designated by the Commissioner of Developmental Services (see below), and
4. requires individual plans to cover behavioral therapy as part of ASD services.

The bill defines applied behavior analysis, for individual plans, as the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including direct observation, measurement, and functional analysis of the relationship between environment and behavior to produce socially significant improvement in human behavior. (This is the same definition of "behavioral therapy" used for group plans).

DSS Commissioner's Designated Services and Interventions

The bill requires the developmental services commissioner, in consultation with the Autism Spectrum Advisory Council, to designate services and interventions that demonstrate empirical effectiveness for treating ASD. The commissioner must update the designations (1) periodically and (2) whenever he deems it necessary to conform to changes recognized by the relevant medical community in evidence-based practices or research.

For individual and group insurance plans, the bill specifies that behavioral therapy be consistent with these services and interventions.

COVERAGE FOR BIRTH-TO-THREE SERVICES IN INDIVIDUAL AND GROUP HEALTH INSURANCE POLICIES

The bill repeals coverage limits for services through the Birth-to-Three program. Birth-to-Three provides services to families with infants and toddlers who have developmental delays or disabilities. By law, individual and group health insurance policies must cover medically necessary early intervention services for a child from birth until age three that are part of an individualized family service plan. Current law limits coverage to $6,400 per year per child, up to $19,200 for the three years, except that coverage under a group plan for a child with ASD who is receiving early intervention services is $50,000 per year and $150,000 in total (CGS §§ 38a-490a and 38a-516a).

INSURANCE DEPARTMENT DATA COLLECTION WORKING GROUP

On or before October 1, 2015, the insurance commissioner must convene a working group to develop recommendations for uniformly collecting behavioral health utilization and quality measures data from:

1. state agencies that pay health care claims,
2. group hospitalization and medical and surgical plans established by the comptroller for state employees and certain other individuals,
3. the state medical assistance program, and
4. health insurance companies and HMOs that write health insurance policies and health care contracts.

The recommendations' purposes must include protecting behavioral health parity for youth and other populations.

Members

The working group consists of the (1) insurance commissioner, (2) healthcare advocate, (3) social services, public health, mental health and addiction services, children and families and developmental

services commissioners, and (4) the comptroller, or any of their designees. It may also include representatives from health insurance companies, HMOs, or any other members the insurance commissioner deems necessary and relevant to carry out the group's duties.

Data Collection and Recommendations

Under the bill, the group must determine the data to be collected. The data must inform analysis on:

1. coverage for behavioral health services;
2. adequacy of coverage for behavioral health conditions, including ASD and substance use disorders;
3. the alignment of medical necessity criteria and utilization management procedures across the agencies, plans, programs, companies, and centers from which data is collected;
4. the adequacy of health care provider networks;
5. the overall availability of behavioral health care providers;
6. the percentage of behavioral health care providers that are participating providers under a group hospitalization and medical and surgical insurance plan established by the comptroller for state employees and certain other individuals; and
7. the adequacy of services available for behavioral health conditions, including ASD and substance use disorders.

The recommendations may include data such as:

1. per member, per month claim expenses;
2. the median length of a covered treatment for an entire course of treatment by levels of care;
3. utilization review outcome data grouped by levels of care, age,

categories and levels of review;

4. the number of in-network and out-of-network health care providers by location and provider type,

5. health care provider network management data by location and provider type, and

6. health care provider network fluctuations, the cause of such fluctuations, and the decisions made by health insurance companies, HMOs, and state agencies regarding the approval of health care providers to join a health care provider network.

By January 1, 2016, the insurance commissioner must submit the group's recommendations to the (1) Governor and (2) insurance, human services, public health, and children committees.

BACKGROUND

Related Federal Law

Under the federal Patient Protection and Affordable Care Act (P.L. 111-148), a state may require health plans sold through the state's health insurance exchange to offer benefits beyond those included in the required "essential health benefits," provided the state defrays the cost of those additional benefits. The requirement applies to benefit mandates a state enacts after December 31, 2011. Thus, the state must pay the insurance carrier or enrollee to defray the cost of any new benefits mandated after that date. Due to the federal Employee Retirement Income Security Act, state insurance benefit mandates do not apply to self-insured plans.

Related Bill

SB 1085, favorably reported by the Insurance and Real Estate Committee, expands certain individual and group policies' required coverage of mental and nervous conditions. ASD meets the definition of a "mental and nervous condition."

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 19 Nay 0 (03/19/2015)